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FROM SECRECY TO TRANSPARENCY: ACCOUNTING AND THE TRANSITION FROM RELIGIOUS CHARITY TO PUBLICLY-OWNED HOSPITAL

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Geraldine Robbins * and Irvine Lapsley**

*National University of Ireland, Galway (Geraldine.Robbins@nuigalway.ie)

** University of Edinburgh (Irvine.Lapsley@ed.ac.uk)

Abstract

This paper examines the experiences of a publicly owned hospital which had formerly been part of a religious order of nuns. This paper presents novel findings to extend our understanding of the emergent theory of transparency in the public sector. The literature on secrecy and transparency is drawn upon to inform a case study investigation of the use of accounting under both forms of ownership. This reveals both the continuing influence of this hospital's prior existence and the difficulties of adapting to public ownership. The findings reveal the tensions of the change from secretive religious organisation and history of parsimony to current public sector organisation. The end state of public sector ownership brings its own difficulties, with accounting systems failing to achieve the aim of transparency.

Keywords: charity; religious secrecy; public ownership; transparency; health care.

Introduction

This paper addresses the increasingly topical issue of transparency (Heald, 2006a, 2006b, 2012 and 2013; Hood and Heald, 2006; Meijer, 2009, 2012, 2013) in publicly owned entities. The nature of transparency in organisations is a matter of some complexity (Hood, 2010), which some commentators regard as overvalued (Etzioni, 2010) and which some organisations apply with a lack of subtlety (Roberts, 2009). The specific focus of this study is on transparency of accounting information in health care, which is recognised as an area of particular complexity for public sector accounting (Brinkerhoff, 2004; Blomgren, 2007; Lavay and Waks, 2009; Knudsen, 2011). While the subject of health care accounting has attracted the attention of many

researchers over the past few decades (Broadbent and Guthrie, 2008), the major efforts of researchers to date have been on publicly-owned hospitals. In this paper we examine the experiences of an organisation which has shifted from the voluntary, non-profit, charitable sector to the public sector. Voluntary (non-publicly owned) hospitals play a significant role in health care in Ireland with five of the six largest Dublin hospitals still having voluntary status. This paper contributes to our understanding of change processes in public service organisations, particularly as they affect accounting. It also extends our understanding of the nature of non-profit organisations and the challenges they face in contemporary society. This paper also contributes to the emergent theory on transparency by extending its primary emphasis on external accountability to include internal transparency and the visibility of accounting to key actors *within* public service organisations (Heald, 2012).

This paper proceeds in the following stages. In the first section, the theoretical framework of the contrasting worlds of *religious secrecy* and *public sector transparency* are explored. Second, the research context of the non-profit organisation in this study is examined and the research design - a field study, based on a case study hospital over the years 2002 - 2013 is explained. In the third section of the paper, there is an analysis of the experiences of this hospital on its move from the non-profit to the public sector, through the lens of key actors involved in the case study hospital. Finally, conclusions are set out.

Theoretical Framework: Secrecy, Transparency and Visibility

The specific focus of this study is on an acute non-profit hospital, which was founded and managed by a religious order until its transfer to public sector ownership in 2001. The distinctive values of religious organisations (Wolfe and Pickard, 1980, p.61; Laughlin, 1990; Booth, 1993) present an interesting accounting research context, which remains an area of relative neglect (Parker, 2002; McPhail, Gorringer and Gray, 2005; Carmona and Ezzamel, 2006). The manner in which we study and understand the work of religious organisations is becoming more sophisticated, as we shift from earlier, simplistic notions of how religious organisations conduct themselves (Jacobs, 2005). This issue is addressed in this paper.

The particular concept this paper seeks to add to is a more comprehensive understanding of the role of *secrecy* in the work of religious organisations (Simmel, 1906; Simmel, cited in Wolff, 1950). The attribute of secrecy in organisations generally, and specifically in religious activity, contrasts with the public sector preoccupation with *transparency* and merits further study (Hood, 2006; Birchall, 2011; Costas and Grey, 2014). This tension is exemplified in this paper, by examining the practices of this voluntary hospital which has moved from religious to public sector ownership, at a time when the public sector is in the midst of significant managerial reforms. These issues are explored further in the context of (1) accounting and secrecy in religious organisations, and (2) public sector transparency, especially in the field of health care.

1. Accounting and Secrecy in Religious Organisations

There is a limited literature concerned with accounting in religious organisations (Abdul-Rahman and Goddard, 1998; Quattrone, 2004) despite the social significance of religious institutions (Parker, 2002). In his seminal study of accounting in churches, Laughlin (1990) observed a fundamental distinction between beliefs in spiritual issues (the sacred) and systems used to support them (the secular). This distinction of sacred and profane draws on Durkheim's thesis that all religion has this fundamental characteristic. In Laughlin's (op. cit) terms, accounting is seen as a support activity and is profane: it is an irrelevancy to the core of the church organisation. There is some, limited support for this distinction as an explanation of how accounting is used within religious organisations. For example, an early study by Wolfe and Pickford (1980) documented the limited role for accounting in the Church of Scotland. This study revealed arcane accounting practices, which narrowed accounting to specific funds (general and specific trusts) located within specific boards of the church, which removed it from the central activity of the church and rendered it invisible to a core membership. Also, Laughlin's own (1988) study of the Church of England noted how the church commissioners used its accounting system to 'purposefully' make themselves accountable both to the sacred church and to the

profane state to secure its continued existence. In this study, Laughlin found that the accounting system was designed to address accountability concerns rather than internal decision-making. However, Espejo, Manjón and Sánchez-Matamoros (2006) found that there was a shared perception that rendering accounts was part of the sacred sphere, yet accountability was considered a profane tool.

However, for some time before this Booth (1993) argued that the construct of the secular divide of the 'sacred' and the 'profane' should simply be regarded as a theoretical ideal. Furthermore, Jacobs (2005) has challenged this dichotomy as an oversimplified representation of organisations which interact with employers, members, the wider public, and the state in complex ways. More recently, Bigoni, Gagliardo and Funnell (2013) find that secular accounting and accountability practices were not considered as inevitably antithetical to religious values, as would be expected by Laughlin and Booth. The 'sacred/profane' dichotomy sheds light on the practices of religious organisations, but it is too narrow and too static to capture the subtleties of religious organisations and the dynamic of their organisation. However, the concept of the 'sacred' *is* fundamental to religious organisations. In this study the concept of the sacred is explored further, in the context of secrecy and religion.

From the earliest times, religious or sacred activities have been associated with secrecy (Simmel, 1906; Bok, 1982; Bolle, 1987; Duncan, 2006). This link between religion and secrecy is widespread. Etzioni (1999) observed how advocates of rights to privacy frequently employed the term 'sacred' to justify these rights, although these people did not otherwise draw on religious terminology, images or beliefs. This claimed right to privacy reveals the fundamental attribute of secrecy: hidden knowledge (Mathewes, 2006). Indeed, Bok (1982, p.6) sees concealment or hiding as the defining trait of secrecy. Secrecy within a religious order can be seen as a mechanism which fosters feelings of brotherhood, of togetherness, especially amongst those inside the order against non-believers (Bok, 1982). But secrecy within a religious organisation may also fulfil important control functions. Control over secrecy may be necessary to protect the identity and values of the members of the religious order (Simmel, 1906; Bok, 1982).

More importantly, the emergence of secret activity is most closely associated with change, transition and transformation (Simmel, 1906; Hazelrigg, 1969; Bok, 1982; Middleton, 1987). Hazelrigg (1969) depicts a scenario of transformation which brings with it the need for the protection of secrecy. In this way, the exercise of control over secrecy helps to guard against change, growth or decay, progress or backsliding (Bok, 1982). Thus, secrecy is more associated with power and change rather than authority and stability (Middleton, 1987). This refuge in secrecy as a form of protection in a time of transition is most evident in the behaviour of religious movements (Simmel, 1906) and can be seen as a protection of identity (Costas and Grey, 2014).

The manner in which this control through secrecy is exercised contrasts with the dichotomy of the sacred and the profane (Laughlin, 1988; 1990). Hazelrigg (1969) depicts the role of secrecy as the means of manipulation and control of *information* as the central variable in social organisation. In the exercise of this control, the use of information which might be regarded as alien to the religious order, as remote from its everyday experience, facilitates secrecy (Middleton, 1987). This concealed knowledge of information (Bok, 1982) need not be fully understood by the key actors – the crucial issue is their ability to control the flow of this information (Middleton, 1987). Accounting and financial information can have a central role in this process, according to Simmel (1906). Financial values have distinct attributes which facilitate the dissimulation, the concealment of actions and intentions according to Simmel (1906): compressibility, an abstract nature, and the possibility of action at a distance. These attributes facilitate an otherwise unattainable level of secrecy. This dissimulation is seen as most effective when exercised by the central authority of the religious organisation (Simmel, 1906; Hazelrigg, 1969). These observations on the nature and prevalence of secrecy (in this case in religious organisations) creates a tension with the rise of transparency in contemporary society as a kind of cultural idea (Birchall, 2011). Next we discuss the nature of transparency in public sector organisations.

2. *Public Sector Transparency*

The above discussion of secrecy contrasts with a fundamental, desired attribute of accounting and management in public sector organisations – transparency. Transparency may be seen as an effective remedy to secrecy (O'Neill, 2006). However, transparency may be defined and described in many ways (Hood, 2006). The New Public Management (NPM) focus is a results-orientation which encourages scrutiny of public sector organisations and accountability for results (Hood, 1991). The development of accountability increases the transparency of organisations by increasing the number of things that are made visible and increasing the number of ways in which things are made visible (Gray, 1992, p.415). NPM reforms have centred around “enhanced transparency in organizational functions” and greater performance specification and monitoring (Guthrie, Olson and Humphrey, 1999, p.216).

In the context of this paper, transparency may be defined as denoting “government according to fixed and published rules, on the basis of information and procedures that are accessible to the public” (Hood, 2001, p.71). This descriptor of transparency emphasises an outward facing, external accountability regime for public service organisations. However, the mirror image of this external accountability is an enhanced internal transparency of accounting information – broadly defined – *within* public service organisations (Heald, 2012). In Heald’s analysis, vertical accountability, which is a characteristic of hierarchical public sector organisations, is always accompanied by horizontal pressures for *inwards* transparency within the organisation (Heald, 2012). This is the logical outcome of a new managerial regime ushered in by NPM in which managers have to respond to financial and performance information and this information is then shared beyond the boundaries of public service organisations with external stakeholders as a necessary part of public accountability. *In this way internal transparency* can be seen as an essential component of effective managerial decision making and control systems (Schedler, 2003; Ahrens and Chapman, 2004; Wouters and Wilderom, 2008; Chapman and Kihn, 2009). This phenomenon of internal transparency is related to the strand of accounting literature which has observed the increased *visibility* of accounting information, particularly in government organisations, as a means by which the

efficiency of key actors in organisations can be observed and tracked as a part of performance management systems (Hopwood, 1990, p.416; Miller and O'Leary, 1994, p.99).

This aspect of the modernisation of public services has given weight to transparency as a desirable attribute per se, as the following comment by Hood (1996, p.155) explains:

budgets are becoming more 'transparent' in accounting terms, attributing costs to outputs and measuring outputs by qualitative performance indicators.

This observation by Hood captures the manner in which internal accounting visibility and external accountability coalesce in the achievement of transparency. The intrinsic merit of transparency as a feature of public management is advanced by Shah, Murphy and McIntosh (2003). Transparency becomes accountability by turning measures into targets (Strathern, 2004), and underpins systems of measurement that require the setting of some ideal level of attainment. The power of transparency lies in its value to others to control from a distance (O'Neill, 2006). Indeed, Hood (2006) describes 'transparency' in public management as having acquired a 'quasi-religious' influence. However, transparency is not something that can be requested 'it has to be institutionalized through transparency legislation, departmental policy or at the least, bureaucratic daily practice' (McGregor, 2003, p.169). Transparency without accountability is pointless (OECD, 2008, p.7), it is not an end in itself but a powerful tool to improve accountability by countering opaqueness (Roberts, 2009).

There are different dimensions to this emphasis on public sector transparency. On the one hand this desirability is seen as essential in promoting effective public accountability (Koppell, 2005). However, it is also seen as having a wider relevance to all areas of the public sector, in general, but health care (see Lowe, 2000), in particular. Historically, accounting and financial matters in health care have had a limited visibility to key actors within public organisations (Blomgren, 2007). In the early 1900s in the UK, Burdett's system of hospital accounting contributed to the standardisation of hospital administrative systems (Jones and Mellett, 2007). Accounting in many health care organisations has moved "centre stage" to the extent that the cost of procedures has become commonplace in the discussion of the

provision of care (Jones and Mellett, 2007). It is through financial and management accounting practices that managerial and public accountability is achieved in modern-day organizations (Messner, 2009). Accounting in contemporary societies follows the provision of state funding to mostly state-owned organizations and is the mechanism which facilitates hierarchical control and upwards transparency (Heald, 2012), using standardized financial systems which facilitate control from a distance (Jones and Mellett, 2007). A well-designed hierarchy of reporting documents is essential to underpin meaningful transparency (Heald, 2012), thus allowing users to drill down from an overview to relevant segmental details as needed.

NPM reforms have accentuated the need for greater transparency from health care organisations (Levay and Waks, 2009). The pre-NPM world of health care organisations is depicted by Lapsley (1992, pp. 237-238) as a context in which the senior accountant was called 'the Treasurer'. In the pre NPM era, Lapsley (1992, p.238) characterised the *invisibility* of accounting information as an absence of meaningful budgets, and treasurers as mere bookkeepers with a major focus on achieving an overall financial balance. Lapsley (1992, p.238) described NHS internal accounting as 'financial management by stealth' in the pre NPM era. This lack of transparency continued for some time as the path to the introduction of budgets and costing information in the NHS was a slow and tortuous process (Lapsley, 1994; 2001).

The achievement of transparency may be considered to be of particular significance in the complex arena of health care, which touches many lives and in which the multi-professional environment has been characterised historically as dominated by a divide between health care professionals, on the one hand, and the management or administrative cadres, on the other hand (Coombs, 1987, Jacobs, Marcon and Witt, 2004) but more recently by greater involvement of clinical managers in management control practices (Lethonen, 2007; Pettersen, 2013; Veronesi, Kirkpatrick & Vallascas, 2013). Specifically it is recognised that, within health care, both internal and external transparency are necessary for the effective functioning of health care organisations (Martin, Giacomini and Singer, 2002). The particular focus of this paper is on internal transparency and visibility of accounting information, but we

recognise that this circumstance is inextricably linked with issues of external transparency.

Research Context and Research Design

This paper examines the use of management accounting in a voluntary, religious, non-profit acute hospital in Ireland which transfers to public ownership. The major dominating feature of the context in which this hospital operates is the importance of religion, specifically, the Roman Catholic Church in Ireland. In the 19th century the voluntary, non-profit hospital movement was encouraged and supported in Ireland by the Roman Catholic Church (Robbins and Lapsley, 2008). As part of this movement, voluntary hospitals were established in the 19th century and continue to operate in the present day. However, these voluntary hospitals had a distinct religious ethos – they were founded to care for patients’ spiritual needs as well as to provide medical care. These religious voluntary hospitals received support not only from the Catholic Church, but also from leading members of the medical profession who were members of the Roman Catholic faith (Barrington, 2003). These voluntary hospitals were also supported by many nuns, female members of the Catholic faith, who worked for nothing, often donating their wages to the hospital in which they worked (Wren, 2003).

However, despite the pervasive influence of the Catholic Church in Ireland, the exposure of the Irish economy to ideas of the New Public Management (Hood, 1991, 1995) is also a factor in understanding public services in the Irish context. While the international spread of NPM ideas has been documented by Hood (1995) and by Pollitt and Bouckaert (2000), the Irish Government was a late adopter, but a distinctive late but decisive adopter. Indeed, the Irish Government codified NPM ideas as best practice in its Public Service Management Act of 1997. New legislation was introduced in various part of the public sector – for instance in health, local government, justice. In the health sector, the Health Amendment Act of 1996 together with other sectoral legislation intensified pressures on traditional, bureaucratic public services to adopt new management techniques, procedures and ways of thinking (Robbins and Lapsley, 2005). This meant that the hospital in this case study was

shifting from the non-profit sector to a public sector which was in the process of implementing far-reaching management reforms.

The case study approach adopted in this paper has been endorsed because of the richness of the data (Stake, 1995; Ahrens and Dent, 1998; Chapman, 2008). . The current case study enables the study of the context in which management accounting is practised by tracing practices, over time (Bryman, 2000, 2004; Chapman, 2008; Yin, 2009). This research approach involves probing and clarification and retrospective accounts which can be collected to foster a longitudinal perspective (Ritchie and Lewis, 2003, p.53).

A significant advantage of case studies is the capability of using a variety of techniques for data collection (Stake, 1995; Bryman, 2000; Yin, 2009). Within the present case study, the research team used the following data sources: (a) documentation (examples of accounting reports, internal reports), (b) archival records (minutes of Board of Directors meetings, together with supporting documentation), (c) some limited observation and (d) interviews with key informants at three levels – MT hospital, regional health authority and Department of Health.

Both sources of data (a) and (b) provided valuable insights into the everyday world of the case study hospital. This hospital has been named Maria Theresa (or MT) hospital for reasons of confidentiality. The material was collected over the period 2002-2013 which reflects Bryman`s (2000, p.242) approach that, in detailed case study investigations, researchers should `keep in touch with, and return to`, the site of their investigation.

The third source of data - observation – was limited because there was limited time for observation, but also because it was not feasible to undertake observation over the life of the hospital including its prior life as a non-profit hospital. To the extent that there was observation in this research it was non-participant and `on the periphery of the action` (Bryman, 2000, p.153). As such, this use of observation was essentially supplementary to augment documentary materials and interviews (Robson, 2002, p. 312).

The final source of data (d) was interviews with key informants (Jones, 1996). This was a carefully designed nested set of interviewees (Lewis, 2003, p.54) who were well placed to provide insights from a variety of perspectives which facilitated a comparison of the Maria Theresa Hospital both as a charity and as a publicly owned entity. This included twenty-four interviews with: past and current management staff; clinicians and nursing staff many of whom worked there over this eleven year period, staff from the charity era; oversight officials in the Regional Health Board and the Department of Health who had experience of dealing with MT hospital, both as a charity and as a publicly-owned hospital.

The *first* level of interviews of key informants was with senior members of the MT hospital. *Second*, management at the next level down at MT were interviewed. These first two tranches of interviews also afforded the opportunity to investigate both experiences of MT hospital as a charity and as a public hospital as there was continuity of employment in both organisations for senior members of the team – the clinical staff – hospital consultants and nursing staff. The final interviews with hospital staff were completed in 2013 - two further consultant hospital doctors (Clinician 3 and 4), a senior nurse manager, and the finance director.

Third, the research team identified key informants who had direct experience of the era of MT as a charitable hospital: a senior member of the religious order who had had management responsibility in the charitable hospital era and who continued to be a presence in the new public hospital, a member of the MT Board of Directors from 1990-2001 when it was a charity, and the senior hospital finance staff.,

Fourth, four interviews were held with senior officials at the Regional Hospital Board who had an oversight responsibility for the MT hospital when it was both a charity and publicly owned. These key informants had regular contact with the management of MT in the charitable and public ownership eras.

Finally, the Assistant Secretary and the Assistant Principal, both senior civil servants in the Department of Health, were interviewed. Each had oversight experience of MT hospital as a charity and as a publicly owned hospital. In total, 24 interviews were held. These were semi-structured and lasted one and a half to two hours. Following transcription, a themed analysis was prepared.

The Case Study: The Transition to a Public Sector Hospital

Although the hospital transferred to public ownership in 2001, the research team observed that it has retained many of the symbols of its former religious ownership. A strong religious influence is evident within this hospital. The religious order's four core values: Dignity, professionalism, justice in the workplace and compassion underpinned their work in the hospital and are still visible in the out-patient clinic in the form of a wall-mounted framed poster. This value statement notes: "that accountability is an essential component of our service". It also states the religious orders view on the use and care of resources: "We use all our resources to help others and take every precaution to ensure that they are used or stored with care". A further manifestation of the lingering religious influence is the retention of a large crib (each December) and a large religious statue inside the hospital entrance, to mark its Christian origins. The hospital chapel remains open to patients, staff, visitors and locals on a daily basis. Other examples include notices on walls with quotations from the Bible. For example, one hospital director had the statement that "the patient's record is a *sacred* trust". This transitional state is typical of the passage from secrecy to openness (Simmel, 1906). However, despite these lingering indications of where this hospital originated, there were strong influences which emerged from public ownership. These influences were (1) the shift from the secretive workings of the religious voluntary organisation to a public sector one, (2) inadequate accounting information systems as a barrier to public sector transparency, and (3) the tensions around public sector transparency and resource constraints in MT as a public sector hospital. These three strands of MT hospital influences are examined next.

1. From Religious Secrecy to Public Sector Transparency

The simple interpersonal systems for solving financial problems which served the nuns well in an earlier era could no longer support the growing more formal hospital organisation.

My aunt and her friend helped the nuns a great deal. She would go and have tea with them and they would set out their problems in private e.g. we have no radios in the

public wards, so the cue was ... “how do we get radios in the public wards”? ... and my aunt would help with fundraising.

(Ex Member of the Board of Directors)

Such informal systems which relied heavily on philanthropy, benevolence and informal contacts with people of wealth and means could not sustain the hospital and provide for its equipment and facilities needs given the growth in technology costs, increasing sophistication and cost of medical equipment and the rising expectations of patients and their families. As needs arose for funding, the religious order and hospital managers would approach the Department [of Health] for assistance.

We’d blaze a trail up to Dublin. We’d sit in front of somebody in the Department of Health and we’d cry until we’d get something.

(Clinician 1)

The nuns in charge of this hospital did not see the need to develop accounting information systems, relying instead on cash-based information held centrally (Simmel, 1906; Hazelrigg, 1969) to manage finances in secret. This accords with views of how religious ‘sacred’ organisations function (Simmel, 1906; Hazelrigg, 1969; Middleton, 1987). Members of the religious order working in the hospital were paid an amount for their work but it was unclear to them how much they received, as this member revealed:

We just didn’t know what we were paid because it didn’t come to us.

(Member – religious order)

Salaries for nurses were paid directly to the Order for the benefit and upkeep of the religious community. Under ownership of the religious order of nuns there was a great deal of secrecy over the management of the hospital. Whilst there were structures in place such as the Executive Team and Hospital Board there was a lack of communication of information about the change in ownership to any staff in the hospital, even those on the Executive Team and members of the Board of Directors similarly were not informed.

It was the nuns and the hospital authority that really did everything with the ... Health Authority and we were kept totally in the dark about it.

(Clinician 1)

When I heard about the exit of the nuns and likely transfer to public ownership, I was quite upset about it. The idea of the state taking over our hospital was just dreadful.

(Ex Board Member)

This contrasts with the Laughlin (1988; 1990) “sacred” and “profane” divide, for here, in this case study hospital, the nuns retained possession of financial information and dealt with the outside world on financial matters and excluded the hospital doctors and almost all members of the Board of Directors from these deliberations. These secretive negotiations echo Simmel (1906) that secrecy is a form of protection in times of transition within religious organisations.

Nuns were involved in the hospital in the pastoral care and mission effectiveness functions for more than eight years following the transfer of ownership. Since transfer of ownership the mission effectiveness function no longer has a chair at the management table. These functions underpinned the ethos of the hospital as illustrated below:

The essence of our order is to serve people with love and compassion. Mission effectiveness involves dealing with staff – trying to inspire and empower staff with our ethos and spirit – to serve with love and compassion.

(Member – religious order)

This observation underlines the distinctive nature of this kind of voluntary organisation. More recently mission effectiveness has merged with bereavement counselling and is carried out by a lay-person. In the era of religious ownership, the mission effectiveness function “looked after retirements and the long service awards. They would, send out notification to people when they were due a long service award at 10, 20, 30 years and it arranged a little function and had a little service in the church and a little tea party afterwards and gave everybody a momentum, a little clock or something” (Senior Nurse Manager). In the public sector era this aspect of mission effectiveness has been replaced by a newsletter.

The pre-transfer period 1997 to 2000 was a time of fiscal crisis for the hospital which was characterised by large operational deficits and a relative invisibility of accounting information, in the more secretive religious organisation. The finance

manager was charged with bringing the hospitals finances into line so that it would appear as a more attractive target for a takeover of ownership and management by the regional Health Authority. Prior to this effort to resolve the fiscal crisis, financial information was not shared with hospital staff. The primary aim of the hospital finance function was to prepare historical financial stewardship reports for the Department of Health.

Our management meetings were different... [speaking of the hospital as a voluntary religious hospital]. They were very defensive. People minded their own corners. There was little sharing of information with the rest of the team.

(ex Finance Manager)

This position changed with the proposed move to public ownership and the move to more transparent management. The new Clinicians in Management structure, put in place during the transition discussions (1999-2001), required a sharing of information that brought issues to the fore that under the old management structure may have been discussed quietly with the CEO, as the former Finance Manager observed:

I didn't mind being open about our overspend. It was no secret..... People were delighted with the discussion of the budgets, they didn't have that before. ... There was great transparency at the management table at the weekly management meeting. I thought it worked very well.

(ex Finance Manager)

The above comment illustrates how working relationships between management staff improved under the new directorate structure and there was significant teamwork and co-operation, as the Director of Care explained:

We would prepare it [a submission for funding] as a directorate.....So say it was something that the Medical Director was doing, I would get a copy of it and I would have a look at it and we would talk about it and we would amend and develop it - that is the way we do our business now.

The above observations are consistent with the advocacy of integration of hospital doctors in hospital management (Abernethy and Stoelwinder, 1990; Eldenburg, Soderstrom, Willis and Wu, 2010). Indeed, the shift from the secretive organisation of the past to the new style, transparent public sector organisation was welcomed by doctors. Consultant hospital doctors considered that they now have more control as

measured by greater representation and voice at the hospital management table, as indicated by the following clinician:

Having a Medical Director, means that we're integrated into management. You see consultants never had a say at management level before and that led to incredible frustration.

(Clinician 2)

Consultant hospital doctors are interested in being part of the management team at this hospital. This contrasts with early studies of clinical budgeting (Jones & Dewing, 1997;) but is consistent with more recent research (Lapsley, 2001; Jacobs, Marcon and Witt, 2004; Scarparo, 2006; Eldenburg, Soderstrom, Willis, Wu, 2010; Pettersen, 2013; and Veronesi, Kirkpatrick, and Vallascas, 2013). In this case study, the clinicians viewed access to accounting information as empowering. The consultant doctors in this hospital accepted the need for applying the principles of business management to management of the hospital. This acceptance of NPM-style ideas of adopting private sector business practices (Hood, 1991) is exemplified by this clinician's statement:

It is vital that we [consultant doctors] have a lot to do with management...Yes, it [the hospital] is a business. It's a caring business but it's a business. It needs business management. Anything that has to do with having to live within financial constraints is a business. Now that was an objectionable word when the nuns were here. They wouldn't look at it that way but I think it's very true, it's a business. (Clinician 1)

For doctors the tension between, and trumping of, clinical accountability over managerial accountability as examined in (Lehtonen, 2007) is exemplified here.

I became much more aware as clinical director, that seventy five, eighty per cent of cost is to do with staff and I would see from a management point of view how hard it is to get resources. ...However, as clinical director my focus is on the patient. It's not on politics, it's not on finance.

(Clinician 3)

The directorate structure put in place in 1999-2000 with its inter functional focus has made visible the lack of financial information available to directorate managers to manage their areas. This resulted in increased demands by managers for more financial information. It became clear how difficult it was for managers to manage in

a vacuum of financial and management information. Public sector ownership has made visible (Brunsson et al, 1998) the dearth of information flowing to senior managers at MT hospital, as the following comment illustrates:

I was twelve months here [in 2001] before I knew what the actual budget was for my area.

(Director of Nursing)

2. *Inadequate Accounting Information Systems as a Barrier to Public Sector Transparency*

While an increased emphasis on transparency opens up a space for accounting (Chua and Preston, 1994; Nahapiet, 1988; Strathern, 2004; Messner, 2009; Roberts, 2009; and Heald 2006a, 2006b, 2012), concerns have been expressed over the capability of hospital accounting systems to make meaningful connections with hospital managers (Preston et al, 1992; Lawrence et al, 1994; Jones and Mellett, 2007). Indeed, the financial reporting infrastructure in this hospital when it was both religiously owned and when it became a public sector hospital, was weak. Control and review of expenditure is difficult given an embedded system which was centred round the stewardship reporting needs of the central government department, the Department of Health, as the former finance manager explained:

The IMR [Integrated Management Report] required by the Department [of Health] had to be produced by the twenty-fifth of the following month. Our accounting systems and staff were geared that way.... It was very difficult to get information in advance of that date. It was really difficult to keep people in check then as regards the budget and budgetary control.

(ex-Finance Manager)

Under the Health Amendment Act 1996, the annual service plan details the planned activity a hospital will deliver for the funding they receive. The budgeting process in the hospital is the service planning process. This process starts midyear. However, this transparency is accompanied by public sector rigidity: a major tension, and this type of tension typifies many public sector organisations (Pollitt and Bouckaert, 2000). The annual budget for the hospital is not known until December each year. The budgeting process is on a year-by-year basis, which results in problems of

planning for services over the medium to longer term, as the following clinician observed:

You see there is no proper budget strategy as such. There is no over-arching plan and that is the way the Department of Health works.

(Clinician 1)

Under public sector ownership, local hospital management were charged with distilling the service plan inputs from all departments into a manageable document for the regional Health Authority. This input was further distilled at regional Health Authority level into a summarised version, which was then submitted to the Department of Health. The subsequent further distillation of the hospital service plan at Health Authority level on occasions created noise and frustrations in the communication process between the hospital, Health Authority and the Department of Health. The version that finally reached the Department of Health is something that the regional Health Authority might have wished for, but local hospital clinical staff were unaware of. And here we have a form of “transparency” in which means and ends can become opaque, dependent on perspective and focus, as the following comment illustrates:

...our last nine page service plan generated after some considerable effort by this department was condensed in the regional Health Authority service plan into a single line which ran something to the effect that ‘The [XYZ department] in MT is continuing it’s co-operation with ‘AN Other’ Hospital’ (60 kilometres away). Now there is absolutely no co-operation between the two departments on any level. So the single sentence that got into the health authority service plan was inaccurate. ... It’s a bit like butting your head against a brick wall.

(Clinician 2)

Other senior clinical staff don’t see the point in a service plan for a demand-led service such as maternity.

When I hear it [service planning] it kind of sends a little shiver up my spine. ...all I can safely say is that we will deliver all the women that come through the door. We won’t refuse any of them if they want to come here. We are not deciding that we have a quota system based on our resources.

(Clinician 3)

The new directorate structure implemented in 1999 facilitated increased transparency. Financial information was visible and openly discussed by management staff on the

Executive Management Team. Before this, financial information was not discussed by those responsible for the management of human and other resources.

There was great transparency at the management table under the directorate structure. Some people didn't like it but from a financial control perspective, I thought it worked very well.

(Ex Finance Manager)

This increased transparency extends beyond senior management. Summaries of monthly management meetings were made available to all staff in the hospital reading room. With these new structures, staff now knew who to speak to, if they had an issue of concern that they would like discussed at a monthly management meeting. This clarity in the information flow was not available prior to the introduction of the new directorate management structures where decisions had been *shrouded in secrecy*. An example of this more open, sharing approach was evident in management meetings at which each member of the management team has to prepare in advance for the meeting and select three key issues of importance for discussion. As the Director of Care expressed it:

Each directorate prepares a monitoring report of what goes on for the month. It means that you have to share information before you go into the meeting. If there is an issue... you will talk with the relevant person prior to going into the meeting, so that meetings don't become disruptive and defensive.

There was a growing understanding of the need for improved financial information as illustrated below and as understood by other clinical staff interviewed as part of this study:

I think accounting and financial information is essential in management of hospitals and we're well behind the international norm. In America, for each patient episode you can get a spreadsheet right down to the paracetamol tablet.

(Clinician 4)

However, improved accounting control systems did not coincide with the move to public sector ownership, although there was some improvement in transparency. Transparency of resource usage provides a challenge for hospital management. The

under investment and under development of management systems over the years continues to present challenges as hospital managers do not have detailed data on resource usage to support explanations for increases in costs and budget overruns.

Despite consensus on the need for improved financial information for management control, development of accounting or financial systems has not occurred.

We are still [2013] using an old system to produce our accounts. It doesn't give us the level of detail we want, in the format that we want it, and the information is provided much too late for any effective management. I have seen systems back 20 years ago that are far better systems than what we have in place here today.

(Finance Manager)

However, hospital accounting staff developed and adapted accounting reports to try to meet the needs of the management team as the team composition changed. For each major cost area (example – radiology, laboratory, IT, maintenance) reports have been developed for those areas showing: year to date pay and non-pay costs, a comparison to last year and a comparison with the budget.

We did it, not because people were asking for it, but more to get information out there that would make people more cost conscious.

(Finance Manager)

The primary aim of empowering managers to manage under the directorate model is frustrated by the lack of management information to inform decision-making. It is not possible for individual hospital managers at MT hospital to make the connection between budgets and activity as the design of the hospital's information system does not facilitate this. For several years post transfer clinical staff did not know their budgets and were therefore unable to begin to control expenditure using existing budgeting tools. This hospital's accounting system (like many others) had developed around the requirements of a central government department, the Department of Health, and this provides little useful information for local management of expenditure at the hospital level. Evidence of expenditure links between clinical activity and financial budgets in terms of controllable costs is not provided because of weak financial systems. The Integrated Management Report is the main means by which regional Health Authorities report on their financial performance monthly to

the Department of Health. The resources of the hospital's finance function are centred round producing historical financial information to submit to the regional Health Authority to facilitate the preparation of the Integrated Management Report of the authority for submission to the Department of Health.

Attempts at greater transparency are impeded by weak and poorly developed financial and management information systems – a legacy that placed little value on such systems in an attempt to do good for the community. The above weaknesses of the MT Hospital's accounting information reveal the frailties of accounting within public sector hospitals. There has been a shift from the invisibility of accounting in the religious, non profit context to the visibility (transparency) and abundance of accounting information in the public sector. But there has been a *disconnection* between the accounting information and its target recipients in the public sector, because of its poor quality and this is an important constraint on the achievement of transparency. In our view this is evidence of reforms based on NPM thinking. However, the expectation of transparency in financial matters is not achieved. A major factor in this is that accounting systems are not fit for purpose to meet the management demands of the new era.

3. *Public Sector Transparency: Financial Constraints*

MT hospital has moved from an accounting famine in its religious period of ownership to one of an abundance of accounting information in the public sector. However, a caveat to this is that much of this abundance is irrelevant information. Early studies of public sector budgetary systems in hospitals (Preston et al, 1992; Lawrence et al, 1994; Jones and Dewing, 1997) have observed this phenomenon, while more recent studies (Lowe, 2000; Frandsen, 2010; Pettersen, 2013; Veronesi, Kirkpatrick, and Vallascas, 2013) bring to light how accounting is increasingly interlinked with medical practices today. Perhaps more importantly, the motivation for MT hospital's move into the public sector was to escape from the financial constraints of that sector. However, the entire history of MT hospital is one of acute financial challenges. This is a story of continuity as MT moves from the charity, non profit sector to the public sector.

Over the years there was recognition by the religious order of the need to both control financial resources and to raise additional finances to augment those received from the government. During ownership under the nuns there were many local initiatives to raise finance for equipment and new technology, as these comments reveal:

There were a lot of local efforts to finance the hospital. For example, the cat scan – we decided we needed a cat scan so we set up a cat scan committee. We went around locally collecting money, and we got the money for the cat scan. Every year for example, during the annual festival we, the student nurses and ourselves too, would go down into the pubs and hotels to collect money.

(Member, religious order)

One thing they were very good at was collecting their income.

(Director of Finance – regional Health Authority)

Years of financial stringency, weak financial management systems and poor strategic planning have left the hospital with equipment capacity deficits. The shift to public sector ownership has made the resource constrained situation transparent. Furthermore, it has accentuated the limited capacity of the accounting systems to provide relevant management information. However, the primary constraint is considered to be insufficient financial resources. This may be partly explained by historical reasons, as the following comments reveal:

We tried I suppose to run the hospital at the most efficient to provide the services that were necessary.

(Senior member, religious order)

Part of the reason there's a problem here with under-funding, is that the nuns actually ran this place on a fairly tight financial basis, that's the way they run things, so I think the hospital has been chronically under-funded for a long time.

(Clinician 1)

Religious ownership had pared things down to the bone. They [the nuns] were very efficient.

(Clinician 2)

This view of parsimony (Hood, 1991) on the part of the religious order is well supported.

As the national hospital budget allocation mechanism is primarily allocated on an historical basis plus an allowance for inflation, current resource constraints are in large part a result of past budget allocations. Financial constraints have always been the greatest challenge facing staff at the hospital, both before and after the transition to public sector ownership. The following comments illustrate how tightly finances were controlled by the religious order.

The religious ownership pared down things. We used to have pencils tied to desks at one stage. We come from that kind of environment, which was very negative in some ways in that you didn't move forward quickly enough.

(Senior Paramedical Manager)

The nuns ran a very tight ship and there really was no fat. (Senior Director – regional Health Authority)

We think we have austerity now [2013] but nothing like when I trained under the nuns. The hospital was managed on a shoestring budget in the nun's time.

(Senior Nurse Manager)

These observations provide further evidence which conflicts with the idea of financial management as profane and an activity beneath the dignity of these nuns (Laughlin, 1988). However, this parsimony also had deleterious effects as the existing weakened capital infrastructure position is a result of past low investment, as this clinician observed:

All of the competition [public hospitals in the regional health authority area] has been upgraded apart from us. ... We have had zip in regards to upgrading for years and it's a gripe I have with the nuns as to how the place is static, but you never stay static, you are running downhill.

(Clinician 2)

We have had to be so careful about every halfpenny we are spending.

(Clinician 1)

Public sector ownership did bring easier access to resources and funding, at least initially, even after the emergence of the national fiscal crisis in 2008. This view on easier access to resources in a public sector context is one shared by staff.

Access to money even though times are tight [2013] appears to be much easier in a bigger [public sector] organisation and as and when a piece of equipment goes down that's vital to us we inform our regional health authority managers and it will be replaced or something will be put in place to keep you covered.

(Finance Manager)

However, while there is access to resources the process of accessing those resources is much more time consuming.

It's so difficult to get equipment or anything now. In the past I told them what I wanted, I got it. Now you have to get your three quotes, you have to fill forms, you have to send emails, I have to get approval from Y, it goes back to X, then it goes back to stores again. I could be waiting months and months and months now. The resources did come but very, very slowly.

(Senior Nurse Manager)

The resource constrained situation in the new public sector context creates tensions and conflicts. Under religious ownership there was a direct line of communication between hospital management and the Department of Health.

The nuns were tough bargaining women and they went up to the Department of Health themselves. They made their case and they came home with their budget.

(Clinician 3)

Public sector ownership has brought with it particular challenges and opportunities: some loss of identity, a greater bureaucracy and slower decision-making. However, there are more opportunities for staff in a public sector organisation connected with other organisations and more resources, at least initially.

We have slowed to the public service pace. When the nuns were here I felt that there was a greater sense of this is our organisation and we will bend over backwards for it. I just get the stronger feeling of demarcation now.

(Senior Nurse Manager)

On the positive side there's more money even though we're overspent like hell there is more money, there are more services.

(Clinician 4)

There is more opportunity. There are new roles for anybody who wishes to have a stab at a new role. ...There are constantly new jobs within the regional health authority.

(Finance Manager)

But against these positive aspects of public sector ownership, there is the challenge of greater bureaucracy and the price of lost independence.

They had the autonomy of a public voluntary hospital and they were able to make changes right there and then. They would consult with their nurses and their doctors, sure they were nurse themselves.

(Clinician 3)

The greatest loss results from the history of parsimony. As noted earlier, the budget is allocated primarily on an historical base which is low relative to other similar sized hospitals. In more recent years the budgetary position has worsened after initially improving post transfer and in the five years thereafter. MT last broke even in 2008 with a budget of €54 million. Since then the budget has been reduced year on year as have all health service budgets.

Remnants of religious ownership linger in a variety of ways: in physical representations – photographs, historical plaques, religious statutory, posters of values, and in more intangible ways – work ethic, team spirit and ethos.

I think the ethos still prevails. That team spirit for survival still lingers. I think also that we think for ourselves. We've had to do that over the years. I would still feel that we are different - that we are more patient centred.

(Clinician 3)

Conclusion

This paper has examined the issue of transparency in public sector accounting and accountability. The particular lens through which this issue was investigated was the experiences of a non-profit, voluntary hospital which transferred to public ownership. This research was based on a single case study and the usual caveat of over-generalisation on the basis of such evidence applies. However, this research does

have interesting findings on the specific case study. In particular, Hazelrigg (1969) has observed that, by definition, empirical research in 'secret' organisations is scarce, but the transition of this organisation to the public sector facilitated research access and this study adds to our understanding of accounting in a 'secret' organisation. This paper also has four wider implications: (1) it underlines the need for contextual studies of accounting information (Miller, 1994; Broadbent and Guthrie, 2008), (2) it extends our understanding of the nature of voluntary organisations: it adds further scepticism over the 'sacred/secular divide' (Laughlin, 1988; Booth 1993; and Bigoni, Gagliardo and Funnell, 2013) and addresses the complexity of religious non profit organisations (Jacobs, 2005; Espejo, Manjón and Sánchez-Matamoros, 2006) by introducing the concept of secrecy, (3) this study also contributes to our understanding of clinical receptivity to accounting information, and (4) most importantly, this study also demonstrates the need to extend the emergent theory of transparency in accounting to *internal* transparency (Heald, 2006a, 2006b, 2012; Hood and Heald, 2006) in public sector accounting contexts. In particular Heald (2012) observes the importance of *inwards* transparency and this study supports this perspective. This underlines the complexity of transparency in action where organisations are confronted with difficult decision making (Meijer, 2013).

Regarding (1) above, this was a study of a voluntary hospital owned and run by a religious order in Ireland, which transferred to public ownership after almost sixty years. Dwindling numbers within religious orders which oversaw these voluntary hospitals precipitated the need to withdraw from both ownership and management of these hospitals, as is the case in this particular hospital - MT. These factors underline the need for a precise and dense contextualisation of the factors at work to better appreciate the interplay of political and social forces and the role of accounting and management in different national and international settings.

On (2) above, re the nature of non-profit religious organisations, the findings of this study further weaken the claims for a 'sacred and secular divide' (Laughlin, 1988). Laughlin's observation was that accounting, as an activity, can be considered profane and something which will not touch the sacred core of religious organisations. This study has shown how a religious order used – albeit primitive – accounting systems

to exercise and retain control over the hospital it founded. This is in direct contradiction of the 'sacred and secular divide'. Furthermore, this study reaffirms the view (Jacobs, 2005) that religious organisations are complex study settings. The particular manifestation of such complexity in this study was secrecy.

Regarding implication (3) above, there is a longstanding interest in clinical receptivity to accounting information. Early studies of this reported an unwillingness of hospital doctors to use accounting information (Preston et al, 1992) and hospital doctors regarding accounting information as alien (Jones and Dewing, 1997). However, more recent studies have revealed changes in clinical work practices as a consequence of implementing casemix accounting in hospitals (Lowe, 2000); clinical use of information where it suits their purposes (Lapsley, 2001); a willingness on the part of doctors to engage with what they regard as appropriate accounting information (Jacobs et al, 2004); and a desire to make connections between accounting information and clinical governance where this development enhances their control of circumstances (Scarparo, 2006), and greater efficiency in use of resources by doctors where they have been involved in designing the accounting system (Eldenburg, Soderstrom, Willis, Wu, 2010). The early view in the literature of clinical disinterest, resistance and hostility is further challenged in this study setting, where there is a consistent willingness on the part (of admittedly a small cohort) of clinicians and other staff over an extended period (eleven years) to engage with financial information. In this case, access to accounting and financial information was seen as a possible empowerment of the clinicians. However, the reality proved to be different, as discussed next.

Regarding (4) above, the religious organisation in this case study shifted from a setting in which there was considerable intra-organisational secrecy to an environment which expected considerable *transparency*, especially of accounting information. However, the public sector context brings with it its own set of difficulties over the (lack of) sophistication of accounting information, the rigidities of large scale bureaucracy and the tensions of seeking management solutions in resource-constrained situations. The historic tight management of resources has had an influence on current budget allocations since these are made predominantly on the basis of historical provision. Resource constraints were exacerbated across the entire public sector as a result of the fiscal crisis in Ireland as in many other countries from

2008 onwards. Resource constraints, persisting from historical and contemporary reasons, continue to lead to tensions and frustrations for staff at the hospital. Accounting in this case study setting is geared towards stewardship concerns rather than as a resource for managerial decision-making of these scarce resources. The underlying accounting systems are blunt, inflexible and incapable of providing meaningful management information. There have been some innovations in accounting reports by accounting staff, outside of the existing accounting system, which have focused on cost control and have proved useful. There is both a greater volume of, and a greater visibility of accounting information but this is not sufficiently context specific or aligned with organisational structures and processes to facilitate more effective management. This raises important questions about transparency: the quality of information, the ability of recipients to interrogate it, and the capacity of recipients to act on available information – all are important dimensions of a comprehensive theory of transparency. In this context, the public sector change provides an impetus for much more detailed accounting information from hospital management for transparency, than that prescribed in its former existence as a non profit hospital owned and operated by a religious order. But, in this case study of a hospital in transition, the paradox is an outcome in which ‘more’ accounting means ‘less’ in terms of connections made with managers in the use of resources. What is provided facilitates stewardship and limited upwards transparency (Heald, 2012) for those managing from a distance, rather than meaningful information for management control. Accounting information here is opaque. Yet, transparency is intended to counter opaqueness (Roberts, 2009). In the brave new era of the NPM, the public sector hospital offers more *transparency*, but little *meaningful* accounting information for hospital managers.

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